whole costly, illogical, and misconstrued plan will collapse sooner than I ever predicted.

K C HARVEY

Medical Centre,
Talgarth,
Powys LD3 0AR

Starting again with clinical research

SIR,—The Medical Research Council committee referred to by Dr Richard Smith[1] was not set up "to examine the poor performance" of the Clinical Research Centre (CRC); this is a description that begs the question. The MRC Epidemiology and Medical Care Unit is independent of the CRC, though it enjoys many links with it. As the committee was not concerned with the unit, I can comment from close experience but with detachment.

The committee's report specifically stated that it was not charged with any detailed assessment of the quality of the CRC's scientific work, an omission that has understandably led many to doubt whether criticisms of the CRC have been soundly based. In my experience, the council goes to great lengths to ensure that its decisions are reached as fairly as possible and are seen to have been so. It is a matter for regret that in the minds of many outside as well as within the CRC this seemed not to happen on the one occasion when it perhaps mattered most.

All concerned must now ensure that the council's clinical research initiative is successful. This partly depends on proper appreciation of the contribution and skills of CRC members who transfer elsewhere. The folklore basis for the CRC's allegedly "poor performance," which the news item relied on, should be abandoned. I have little doubt that with the dispersion of CRC staff the origins of major advances reported from other centres during the next few years will be traced back to the CRC and Northwick Park.

T W MEADE

MRC Epidemiology and Medical Care Unit,
Northwick Park Hospital,
Middlesex HA1 3UJ

1 Smith R. Starting again with clinical research. *BMJ* 1991;**302**: 254-5. (2 February.)

Future of the NHS

SIR,—The interesting events of budget week have relevance both to the past and to the future of the NHS. Had Aneurin Bevan not prevailed over Herbert Morrison in the Cabinet,[1] continued control of many hospitals by local government would in effect have precluded a *national* service. With the radical modification of the community charge we have in fiscal matters a similar shift from local to central control and also evidence of a new and welcome willingness to "turn back" when the evidence of actual or political damage becomes overwhelming.

What has that to do with the future of the NHS? Although damage to health is less immediately apparent than damage to the pocket, the threat of imminent disruption to the NHS has a similar potential for harm to that of the community charge. Fundholding practices, trust hospitals, managerial dominance centred on market values, and an emphasis on competition rather than on cooperation are all disruptive of what should be essentially a unified service, capable of evoking the professional loyalties that have so far upheld it in spite of financial stringency and three messy reorganisations, the last being the worst.

Even now the secretary of state has a chance to limit the damage that he has inherited—by slowing things down until the essential waste and inefficiency of the new model are even more apparent in operation than they already are in prospect and then persuading his colleagues to reverse the worst features. That he has the capacity to do so may be suggested by Polly Toynbee's statement in *The Times Saturday Review*[2] that "It was Baker and Waldegrave, after all, who went down to Chequers with wall charts and graphs to show Thatcher that a poll tax was feasible, even desirable." It remains unclear, of course, which of them pushed harder at the open door; but on the assumption that both of them pushed, such powers of persuasion might be adequate to save from disruption the service which has shown its essential effectiveness and value for over 40 years.

DOUGLAS BLACK

Whitchurch-on-Thames,
Reading RG8 7EN

1 Klein R. *The politics of the National Health Service*. London: Longman, 1983.
2 Toynbee P. Yes, Prime Minister. *The Times Saturday Review* 1991 March 16.

International specialist meetings

SIR,—I am sure many find international specialist meetings[1] beneficial, even inspirational, but in the brave new world of health economics I wonder what the cost-benefit analysts make of such events and what is the optimal frequency of attending international meetings.

Over £500 may be spent attending a conference of a few days' duration, while a full year's subscription to most learned journals costs about 10% of this. Let us assume that an international specialist meeting covers the material of a full year's subscription to four specialist journals—a rather optimistic estimate by common experience. Then we may utilise the same resource in achieving at least twice the educational benefit by spending the money on specialist journals. During most of the year there would seem to be at least one specialist meeting a month that could legitimately be attended, but of course funds rarely permit this. I am pleased that some assessment has been made of the efficacy of attending scientific conferences, but I fear that the financiers may better spend their money in educating us in other ways.

Perhaps with the new technology of communications and video conferencing we may be able to contribute papers and attend meetings by proxy, thus saving the inconvenient and expensive travel arrangements, not to mention the exorbitant accommodation fees that are levied.

W GEORGE KERNOHAN

Queen's University of Belfast,
Department of Orthopaedic Surgery,
Musgrave Park Hospital,
Belfast BT9 7JB

1 Alexander-Williams J, Fielding LP, Goldberg S, Grace RH. Recipe for success in international specialist meetings. *BMJ* 1991;**302**:585-7. (9 March.)

Drug Point

Uterine rupture after termination of pregnancy with gemeprost

Drs PAUL BYRNE and TOKS ONYEKWULUJE (Department of Obstetrics and Gynaecology, Walsgrave Hospital, Coventry CV2 2DX) write: Gemeprost, a synthetic analogue of prostaglandin E_1 (16,16-dimethyl-trans-Δ^2-PGE1), is licensed for softening and dilatation of the cervix in the first trimester, therapeutic termination of pregnancy in the second trimester, and termination of pregnancy in cases of intrauterine fetal death in the second trimester. Experience with many thousands of patients has been reported without serious complications.[1] We observed a case of uterine rupture in a patient who had a pregnancy terminated with gemeprost at 22 weeks' gestation.

A 27 year old woman who was pregnant for the second time had a routine ultrasound scan at 16 weeks' gestation that raised the possibility of a fetal abnormality. She had had an assisted vaginal breech delivery of a baby boy weighing 3430 g after a spontaneous labour two years previously with no complications in labour or in the puerperium and had no history of uterine surgery or trauma. Her serum α fetoprotein concentration was 35 kU/l. Amniocentesis was done at 16 weeks' gestation and a transabdominal chorionic villus biopsy sample taken at 18 weeks. Chromosomal analysis showed 47,XY,trisomy 21. She was counselled and requested to have the pregnancy terminated. This was done at 22 weeks' gestation with gemeprost vaginal pessaries.

Her uterine size was consistent with the estimated gestational age. The cervix was long, tubular, and closed. A pessary of gemeprost 1 mg was inserted into the posterior vaginal fornix. Four further pessaries were used at four hourly intervals. She complained of painful uterine contractions of increasing severity, but no evidence of cervical dilatation was noted. Soon after inserting the fifth pessary she became shocked and the uterine contractions stopped. There was no vaginal bleeding. Uterine rupture was suspected and immediate laparotomy done. This showed a 10 cm diagonal tear on the anterior surface of the lower third of the uterus, extending into the broad ligament on the right side. The gestational sac had been extruded, and a litre of blood was found in the peritoneal cavity. The fetus was removed and the uterus repaired. The patient made an uneventful recovery.

The Committee on Safety of Medicines has had one report of uterine rupture after the use of gemeprost (personal communication); seven cases have been reported to the manufacturers; and as far as we are aware there have been three published case reports. Of the published cases, one was in a multiparous woman who was found to have a fetal abnormality at 32 weeks' gestation,[2] another was in a woman who was gravida nine, para eight who had an intrauterine fetal death at 24 weeks' gestation,[3] and the third was in a woman who was gravida four, para three who had been given gemeprost 10 mg over 48 hours followed by an oxytocin infusion for 22 hours.[4] Our case is notable because of the absence of risk factors for uterine rupture. It is unlikely that routine amniocentesis or chorionic villus biopsy would have predisposed this patient to uterine rupture.

Gemeprost is a very potent prostaglandin analogue and may be equally effective in lower doses than are currently recommended. Smaller doses may lessen the risk of uterine hypertonus and decrease the risk of uterine rupture. The presence of uterine scarring and high parity are well established contraindications to the use of other prostaglandins, and we suggest that these should be considered as absolute contraindications to the use of gemeprost and should be added to the data sheet for gemeprost.

We thank Mr Reed for his permission to report this case.

1 Karim SMM. Clinical applications of prostaglandins in obstetrics and gynaecology. In: Karim SMM, ed. *Cervagem—a new prostaglandin in obstetrics and gynaecology*. Lancaster: MTP Press, 1983:15-43.
2 Henrion R, Oury JF, Dumez Y, Ammous A, Vige P. Un nouvel analogue de prostaglandine E1 dans les interruptions de grossesses tardives, les morts in-utero et les ruptures très prématurées des membranes. *J Gynecol Obstet Biol Reprod (Paris)* 1984;**13**:934-46.
3 Thavarasah A, Siva Achanna K. Uterine rupture with the use of cervagem (prostaglandin E1) for induction of labour on account of intrauterine death. *Singapore Med J* 1988;**29**:351-2.
4 Wiener JJ, Evans AS. Uterine rupture in midtrimester abortion. A complication of gemeprost vaginal pessaries and oxytocin. Case report. *Br J Obstet Gynaecol* 1990;**97**:1061-2.